Dr Sekhar Pillai
Paediatric Neurologist, Paediatrician
SYDNEY PAEDIATRIC NEUROLOGY

Completed form with signature fax to **02 9184 3364**
Or email to **reception.drpillai@gmail.com**

Patient Information Form

*The information is private and **confidential.***

Patient details

First Name: _____ Surname: _____

Address: _____

DOB: ____/____/_____ Male / Female (please circle)

Medicare No. _____ Position on cared: ____ Exp date: ____/____/_____

Private Health Fund: _____ Health fund No.: _____

Parent details

Mother's Name: _____ D.O.B ___/___/_____ Mobile: _____

Position on Medicare Card: _____

Father's Name: _____D.O.B ___/___/_____ Mobile: _____

Address: _____

Email: _____

Referral Details

Referring Doctor's Name: _____

Referring Doctor's Address: _____

GP Name: _____

GP address: _____

Please note that to be eligible for a Medicare rebate on this visit, your **referral letter must be current** (GP referral last 12months & specialist referral last 3months)

It is requested that you settle your account(s) following consultations. A proportion of your payment can be claimed back from Medicare. Thank you for your assistance.

Parent's Signature: _____ **Date**: ____/____/_____

I give permission for my child's medical records to be released to hospitals and to other health professionals if required. Yes: ❑ No: ❑